ACRRM

College Submission

September 2024

Review of General Practice Incentives Proposals

Our thanks for considering our written feedback on the GP Incentives Review proposals.

The College supports the principle of a system shift to a blended payments framework for general practice where this would flexibly enable healthcare team models that can optimally deliver care in rural and remote areas. For our college, key among these should be rural generalist models which will integrate care across primary, secondary, hospital and community-based settings reflexively to local context needs.

The Review proposals engender transformative change to delivery of the country's most essential healthcare services and ACRRM would emphasise that the stakes are extremely high.

This feedback is provided in the absence of key information including on what we consider to be the determinative issues:

- Whether there will be any additional funding attached to the proposals, and
- What the timeframes, order of roll out, and capacity for checks and contingencies will be, in the transition to the new payment's structures.

Absent assurances or detail on these issues, the College cannot make an informed assessment of the net long-term impacts of these changes. This paper does however seek to identify the key risks of adverse consequences to the provision of rural and remote services that must be avoided and provides recommendations on adjustments that offer some positive solutions to progressing the broader agenda while preventing these negative outcomes.

Key risks for rural and remote services:

While detail on implementation is not available, from the information provided, we see significant risk of adverse consequences for rural and remote medical services. The College would stress the need to proceed with care, and with capacity to course-correct in the advent of adverse consequences, especially for the already tenuous access to medical care experienced by people in rural and remote areas and Aboriginal and Torres Strait Islander communities.

- *Rural General Practitioners are not supported within the new architecture.*

  General practice is the cornerstone of healthcare for all Australians and especially critical for people living in rural and remote areas for whom the General Practitioner is often the only medical care provider for whom they have reasonable access. There is no recognition in the proposals of the value of General Practitioners or the need to sustain this workforce in its particularity.

The College notes that as named, the Review was intended to identify mechanisms to *incentivise general practice* however there is no detail at this stage to guarantee that any of the incentives will necessarily be directed to general practice or general practitioners, rather as described they will be directed to the broader primary care designation.

The lack of valuing and future certainty for the profession that this signals is of concern. Broadly, it is recognised that General Practitioner services are under-funded[1] and at record low levels of relative popularity with the emergent medical workforce[2]. It is especially of concern in remote and rural communities where there is a key risk that incentives structures will facilitate a staged transition toward General Practitioner services no longer being available outside of cities.

- *WIP payments are no longer directed to incentivising rural doctors or their advanced skills*

Of serious concern to our College is the recommended immediate term action to redirect Workforce Incentives Programs (WIPs) payments from doctors to consolidated practice income. WIPs are widely recognised as critical to maintaining rural workforces. They are also currently the key incentive to reward attainment of advanced rural generalist skills which are vital to provision of the full scope of necessary medical services in rural and remote areas. This proposal will remove the guarantee that all or any of this incentive will be passed on to practitioners. We see this as likely to have an immediate negative impact on vital rural and remote medical workforce provision. We note that the Consultation Briefing is silent on the issue of the Rural Procedural Grants (RPGP) program which is the other essential tool for incentivising and enabling continuing provision of advanced skilled services by rural doctors. This is also of considerable concern to our College.

- *Further subspecialisation/urbanisation of the emergent medical workforce*

Overall it is not clear that the proposals will address the most essential "incentivisation" problem for general practice services provision, namely the increasing discrepancy in the remuneration and value proposition of (predominantly urban) subspecialisation relative to careers as General Practitioners. It is notable that the term *General Practitioner* does not appear on any of the incentives recommendations.

In seeking to improve incentive structures it should at the outset be recognised that General Practice funding and by extension General Practitioner remuneration, has been systematically eroded over decades. General practice viability and affordability, relies heavily on patient payments via the MBS and bulk-billing. These payments have been subject to either low or frozen indexation for over three decades. This inadequate indexation has effectively resulted in a cost shift from the government to practices and their patients.[3] Similarly, the Workforce Incentives, the Rural Procedural Grants and more Practice Incentives program schedules have not seen any increase to align with inflation, since their respective implementations more than a decade ago.

- *Rural practices fail due to loss of income, insufficient time or resource to adjust business structures to change, or to disparities between loss of old sources of income and availability of new sources of income*

[1] AMA (2022) The General Practice Workforce: Why the neglect must end. https://www.ama.com.au/sites/default/files/2022-11/AMA-Research-and-Reform-General-practitioner-workforce-why-the-neglect-must-end-final_1.pdf
[2] MDANZ (2024) Medical Students Outcomes Database Reports 2015-2024 https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/
[3] AMA (2022) *Why Medical Indexation Matters* https://www.ama.com.au/sites/default/files/2022-11/AMA%27s-plan-to-Modernise-Medicare-Why-Medicare-indexation-matters.pdf

As outlined above, it is unknown how the quantum of potential funding will change and whether there will be any additional funding associated with the new framework.

A further concern for our College is the pace of change of transition and how quickly it is envisioned that the redistribution of funds will occur. We would stress that our members' practices and their income packages have evolved over time responsively to the funding envelopes. Allowing these doctors and their practices sufficient time to adjust to the new arrangements will be critical to the successful implementation of any changes and to avoid serious workforce impacts in rural and remote areas.

ACRRM Recommendations:	
1	The proposals should ensure that implemented frameworks incentivise both advanced rural skills including those provided external to the general practice clinic consistent with the rural generalist scope as well as incentivizing provision of community based general practice services.
2	The recommendations should explicitly recognise that their success will be contingent of additional funding being made available to the General Practice sector through the implemented programs including specifically to rural General Practitioners and Rural Generalists.
3	The recommendations should include explicit recognition of the importance of General Practitioners as a critical workforce that should be sustained and strengthened through the implemented framework.
4	The recommendations should include explicit recognition that rural people deserve access to a doctor with whom they can have continuity of relationship and reasonable access to in-person interactions and that this should be a target outcome of all aspects of the implemented framework.
5	Recommendation 1B to divert WIPs to practices rather than doctors in the short term should be reversed. The WIP and RPGP payments should be maintained in some form, with some clarity provided of the shape the changes might take, if rolled out incrementally over the longer term.
6	The term "multidisciplinary" should be avoided in favour of the term team-based care throughout the recommendations. The recommendations should provide specific instruction that in scope care models should enable context appropriate arrangements that reflect community exigencies especially in remote and rural locations.
7	The proposals should include specific direction: (a) that the imposition of data requirements is subject to a cost benefit analysis of the time and resource cost to provision of primary care in the local setting, and (b) consideration of the practical feasibility of meeting data requirements given the exigencies and resource capacities particularly of small rural and remote practices.
8	Facility should be included within the incentives framework, to ensure primary care services can be provided to people and practices that do not sign up for *MyMedicare*

	especially in rural and remote areas where choices are limited, and for individuals with specific extenuating circumstances related to their privacy.
9	Eligibility of any non-medical practices for support through the General Practice incentives architecture should be contingent on their commitment to demonstrating business structures to enable patient access to continuous care by a General Practitioner though a context appropriate model of care.
10	The Independent Pricing Authority should include an explicit brief to identify the value and from this infer an appropriate incentivization price point to maintain a General Practitioner workforce, including a specified level for those in remote and rural areas. Similarly, it should have a specified brief to identify the value and thereby appropriate incentivization targets for General Practitioners providing rural generalist services.
11	Implementation plans should recognise the potential of the engendered policy changes to trigger loss of vital rural and remote medical workforce and services and ensure that all initiatives are rolled out incrementally with opportunity to expediently identify emergent negative impacts and realign.

Rural Generalism

General practitioners practicing in rural areas are called upon to operate to extended scope and responsibility due to their relative isolation from the full scope of resources, services and specialist staff available in citites.

General practitioners specifically skilled to the rural generalist scope, provide care across the continuum from primary through to secondary care and across the care spectrum in accordance with local exigencies. ACRRM Fellowship certifies these doctors as having attained competency as specialist General Practitioners with the rural generalist scope of practice.

Both generic rural skills and particularly rural generalist skills are vital to ensuring that people living in rural and remote areas can enjoy access to services to meet their most essential medical needs.

> *Rural and remote communities are highly reliant on accessible and comprehensive primary healthcare services, particularly medical services provided by GPs. Rural GP procedural practice can include surgery, obstetrics, anaesthetics and/or emergency services. Procedural GPs play an important role in rural practice because rural areas have limited hospital-based resources and may not have a specialist available to provide these services that within a metropolitan area would require a specific referral-based speciality.*[4]

[4] HMA – KBC Australia (2022) DOHAC Streamlining and expanding procedural programs to improve rural health 26 April 2022 (page 4)

In addition to providing a workforce which can meet critical service needs, rural generalism presents an attractive rural career option for the emergent medical workforce and an effective tool to recruit and retain doctors for rural and remote communities that can provide both primary and other levels of care.

Rural generalist medicine (RGM) continues to demonstrate increasing popularity with the emergent medical workforce and appears to be counteracting declining interest in general practice relative to other specialties. The Medical Students Outcomes Database, has found:

- RGM is now the 6th most popular specialty choice among surveyed graduating domestic medical students, preferred by 7.9% of surveyed students in 2024 (preferred by 6.5% and 8th top choice in 2022[5], and 5% and 9th top choice in 2023).
- General practice (excluding RGM) is the 4th most popular specialty in 2024 preferred by 10.6% of surveyed students. It was the most popular specialty in 2013 preferred by 17% of surveyed students.[6]

The Review Proposals are silent on the issue of how or if rural generalist practice will be incentivised. They indicate that the WIPs which have been specifically designed to support and nurture a rural generalist workforce will be collapsed into broader practice payment over the longer term and in the short term they will be redirected from doctors to practices.

Supporting rural generalism can provide a powerful strategic lever to bring doctors and vital services to rural and remote areas. It is incumbent of the General Practice Incentives architecture that it incentivises this rural workforce and can be leveraged to ensure that they are providing the spectrum of services that aligns with community need.

ACRRM Recommendation 1:
The proposals should ensure that implemented frameworks incentivise both advanced rural skills including those provided external to the general practice clinic consistent with the rural generalist scope as well as incentivizing provision of community based general practice services.

Response to the Review Recommendations

Recommendation 1A

The Australian Government should introduce a new, simplified general practice payment architecture that better supports community and patient needs and encourages high quality, accessible, multidisciplinary care.

In doing so, the new payment architecture should:

- *Comprise a new baseline practice payment that*
- *Enables general practices to flexibly provide multidisciplinary care approaches to their patient cohorts*

[5] Note: Rural Generalist Medicine option introduced to survey in 2021

[6] MDANZ (2024) Medical Students Outcomes Database Reports 2015-2024 https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/

- *includes funding for coordination of the work of the primary care team*
- *is calculated based on patient need, complexity, and rurality*
- *Include payments and/or programs to promote quality and innovation, teaching, afterhours care, targeted programs*
- *Require general practices and patients to participate in MyMedicare*
- *Require general practices to provide comprehensive service delivery information and data to support calculation of reimbursements, planning, evaluation, monitoring of health outcomes and quality improvement*
- *Over time, replace existing Practices Incentive Programs (PIP) and Workforce Incentives Program (WIP) payments while ensuring viability of general practices to meet patient needs.*

Recommendation 1B

The Australian Government should direct all current WIP provider payments to general practices, rather than individual health professionals, to enable flexibility and agility in attracting, recruiting, and retaining health workforce professionals into rural and remote practices.

In doing so, the new Baseline Program Payment should continue to support rural and remote workforce objectives, such as maintaining services and increasing comprehensive primary care in underserved communities.

These recommendations do not detail the future funding that will be attached to the various policy instruments. It is widely recognised that primary care is underfunded[7] and rural and remote services overall relative to urban services are grossly underfunded.[8] Irrespective of the realignment of incentive options, these will continue to fail to incentivise the quality services needed if they are not matched by funding that can change the essential value proposition of general practice.

ACRRM Recommendation 2:
The recommendations should explicitly recognise that their success will be contingent of additional funding being made available to the General Practice sector through the implemented programs including specifically to rural General Practitioners and Rural Generalists.

Recommendations 1 and 1B create an incentivization framework that does not appear to guarantee any funding source will necessarily be directed to an individual General Practitioner, nor to one who practices rurally or remotely, nor to one who has acquired advanced specialised skills to maximise their capacity to meet local service needs in rural and remote areas.

The focus on funding to businesses without consideration to specific workforce impacts presents significant risks that the new architecture will not fulfill key functions:

[7] AMA (2022) The General Practice Workforce: Why the neglect must end. https://www.ama.com.au/sites/default/files/2022-11/AMA-Research-and-Reform-General-practitioner-workforce-why-the-neglect-must-end-final_1.pdf
[8] NRHA – Nous (2023) Evidence base for additional investment in rural health in Australia: NRHA 23 June 2023. https://www.ruralhealth.org.au/sites/default/files/publications/evidence-base-additional-investment-rural-health-australia-june-2023.pdf

- attracting more of the medical profession to general practice,
- bring more General Practitioners to the rural and remote areas of workforce shortage, and
- facilitate more of those rural and remote General Practitioners to attain and retain the special skillset necessary to fill key service needs in rural and remote communities.

A GP is a trained multidisciplinary health professional with special expertise in multimorbidity and early detection of undifferentiated conditions. We are the most cost-effective part of the system (partly due to underfunding) partly due to performance.

Feedback from ACRRM rural doctor

Cessation of WIP and PIP payments and the future of Rural Procedural Grants

The proposed new arrangement would see WIP and PIP incentives replaced over the longer term. In the shorter term it would see WIP payments transferred from being paid to doctors, to practices.

There has been broad recognition that these incentives have been critical to sustaining the financial viability and attractiveness of rural careers and practices.[9] While the additional funding will continue it is not clear what the new incentivization mechanisms will be.

Both the short and longer-term solutions recommended will have the effect of ceasing direct payments to doctors. This will remove the direct policy lever to influence doctors' career and employment decisions and lessen the precision of government funding to impact workforce outcomes. It also comes with considerable risk of adverse outcomes.

1. *Medical workforce not incentivized to practice rurally*

    A key risk is that practices will not pass all or any of these incentives to rural doctors.

    The lack of opportunity to guarantee doctors that these benefits would be part of their employment proposition is likely to have an immediate, negative impact on rural doctor recruitment and retention. This will potentially lead to loss of medical services for individual communities already experiencing doctor shortages. At scale, this sends a strong signal to the emerging medical workforce that they should not view rural careers as well remunerated career options.

    While the College recognises the central importance of locally-based rural doctors, it should also be recognised that locum doctors are critical to ensuring service delivery for many rural and remote services. Many locum services are provided by rurally-based doctors that deliver outreach services to their surrounding communities. As these doctors are not typically attached to the practice, without the incentives that they currently receive, it is likely that many of these doctors will cease providing rural services.

[9] KPMG Effectiveness of GP Incentives Review (2023) https://consultations.health.gov.au/primary-care-reform-branch-primary-care-division/review-of-general-practice-incentives/

2. *Rural services are de-medicalised*

The consultation briefing does not include recognition that people in rural and remote areas deserve or warrant access to a doctor, or aspiration to try to provide them with access to one. Absent of any such commitment or intent, the likely outcome of the incentive structures is broad scale encouragement to rural service operators to transition from *General Practice* clinics to non-medical health professional team services.

Doctors have higher cost structures and by virtue of their scarcity are likely to be able to negotiate a higher proportion of the practice incentives funds received by the practices than other health professionals. In the broader policy context of the scope or practice review, which is seeking to open up health practitioner scopes and their access to MBS and other funding sources, the proposals set a clear profit motivation to practices favouring appointments of non-medical teams. While there may be value to this shift in certain urban contexts where alternative services are not far away, in rural and remote contexts this will commonly lead to practical loss of access to medical care for families.

> *"… I believe that we should be working towards more comprehensive and streamlined team-based cares. However each team member has a role, and we cannot minimise the pivotal role of the GP as the gatekeeper of healthcare. There are several roles that tend to be undertaken by a GP in rural areas should no other local options exist that could be more appropriately managed by another member of the multidisciplinary team. However, the other members of the multidisciplinary team cannot replace the role of the GP. Thus in remote communities there will also be a need for a GP who must remain engaged with the work available and any visiting or resident multidisciplinary team members."*

Feedback from ACRRM rural doctor

3. *Rural loading doesn't support provision of rural services*

The bundling of incentives previously directed to individuals to a corporate identity brings with it considerable risk that funds will *not* be directed to addressing the quality issues for which they were intended.

A key risk is that when rural loading is incorporated into practice payments, these may not be directed toward provision of rural services. Practices may be corporatised and/or headquartered in urban centres. The rural-loading funds may not be passed on by the business owners for the purpose of rural service provision. The beneficiaries of these profits may not live in rural communities and any spillover benefits would also be lost to local economies.

4. *Loss of capacity to value distinctive rural generalist and generic rural general practice skills*

There is no indication going forward that there will be any tool that will value or reward attainment or maintenance of Rural Generalist advanced skills. We note that the proposals are silent on the future of the Rural Procedural Grants Program (RPGP). It was noted that this was 'in

scope' for the review of the efficacy of the Workforce Incentives Programs but is not discussed in the consultation draft. [10]

There is considerable experience of the impacts and efficacy of the current mechanisms in recruiting and retaining rural doctors and it is not clear that future arrangements will maintain this efficacy. [11] For example, the Nous consultancy found 60% of surveyed participants in the RPGP indicated that the program grants influenced their decision to remain practicing in a rural or remote areas 'to a great extent'.[12]

It is of particular concern that the cessation of the Rural Advanced Skills WIP payments is being mooted even as these payments are being rolled out and before any evaluation has been possible. This is likely to undermine their potency as a market signal that RG skills will be valued and appropriately remunerated going forward.

On a more cognitive level, we would highlight the impacts in terms of the sense of disrespect and demoralization that removing these payments before they have even been established is likely to have upon the Rural Generalist profession. These payments are the result of years of advocacy by rural doctors to have their skills, training and heightened professional responsibility recognised and valued.

5. *Loss of rural medical workforce*

ACRRM would strongly advise against proceeding with Recommendation 1B as written. For the reasons as outlined above our College believes this has the potential to have immediate and serious impacts on rural practices and health services ability to attract and retain critical medical services. This will also have negative downstream impacts, as it will send a market signal to emerging doctors considering careers in rural practice, that these careers are not valued and not likely to be well remunerated.

Our feedback from members regarding the proposals has been strongly opposed to this recommendation and to the potential loss of WIP payments over the longer term. Many members have reinforced the position that without the full incentive package they or their colleagues or employees, are likely to cease providing services in rural and remote areas.

> *As I am sure many other college members and non-members have already stated, the change from WIP being made to individual doctors to the practices would significantly disadvantage rural practices in their ability to attract and retain doctors. These payments ensure that rural doctors are able to be adequately remunerated in rural practice, thereby increasing the number of staff interested in working in these locations. The WIP payments also provide some assistance in travelling for continuing professional development - both in terms of the time spent away from a practice to attend CPD as well as the costs associated with travelling. These payments are also of assistance to those*

[10] KPMG Effectiveness of GP Incentives Review (2023) https://consultations.health.gov.au/primary-care-reform-branch-primary-care-division/review-of-general-practice-incentives/
[11] KPMG Effectiveness of GP Incentives Review (2023) https://consultations.health.gov.au/primary-care-reform-branch-primary-care-division/review-of-general-practice-incentives/
[12] Nous Group (2017) Review of the RPGP and GPTSP: Evaluation for the Department of Health. https://www.health.gov.au/sites/default/files/documents/2022/03/review-of-the-rpgp-and-gpptsp-evaluation-report-review-of-the-rpgp-and-gpptsp-evaluation-report.pdf

who need to arrange care for their children while they are at work - with many rural locations having a deficit in childcare options, the ability for one parent to either not work or only work part time is significant. Other options, including engaging a live-in nanny, are also more affordable. As a former Director of Medical Services I have had multiple staff express that without these payments the rural work they were providing would be untenable.

If I am unable to access the full amount, I am entitled to then I would be forced to reconsider my work in these locations. I do not want to stop remote work, but as my experience, skill set, and professionalism are continually devalued by pay discrepancies and policy changes such as these there will come a time where it simply will not be financially worthwhile to provide these services given the extra stress, clinical risk, and lack of support and education in remote areas compared to metropolitan areas.

Although there are some well-run practices that struggle to stay afloat and need more support, I think it is NOT a good policy to support the practice but at increased risk of losing the doctor.

And don't forget that WIP payments only go a very small way towards spouses, partners, not having work or paid employment. Nor the self-esteem gained through "being valued" through being financially paid.

Isolated solo practice is difficult enough without removing the ability to claim WIP and PIP payments because of system neglect of rural patients. I will retire in less than 10 years, the harder it is made to work here, the less likely that I will ever be replaced.

Feedback from ACRRM rural doctor

No explanation has been given as to why the WIP would be removed in the immediate term. This appears to be a high-risk strategy with little evidence to suggest that it will not have a significant negative outcome for rural and remote services both in the immediate and the longer term.

ACRRM Recommendation 3:
The recommendations should include explicit recognition of the importance of General Practitioners as a critical workforce that should be sustained and strengthened through the implemented framework.
ACRRM Recommendation 4:
The recommendations should include explicit recognition that rural people deserve access to a doctor with whom they can have continuity of relationship and reasonable access to in-person interactions and that this should be a target outcome of all aspects of the implemented framework.
ACRRM Recommendation 5:

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Recommendation 1B to divert WIPs to practices rather than doctors in the short term should be reversed. The WIP and RPGP payments should be maintained in some form, with some clarity of the shape changes might take, if rolled out incrementally over the longer term.

Baseline Practice Payment

We note that the Baseline Practice Payment is described as the "core of the new payment architecture". Eligibility for all other incentives depends on meeting eligibility for the baseline payment.

The College sees value in the baseline payment as a mechanism to provide a degree of financial security for rural and remote practices to ensure they have sufficient funding for their continuing viability. If appropriately calibrated, this could fund in accordance with the complexity of the patient mix, the challenges of remoteness, and other key determinants of each practice.

It is noted that baseline payment eligibility will be contingent on practices being embedded in multi-disciplinary care, both practices and their patients signing up to *MyMedicare*, and practices providing comprehensive practice data.

Generally, it is noted that this security would come at the cost of organisational autonomy. The approach would signal a shift away from GP clinics operating as independent businesses and their practice will be more directly dictated by government imperatives. In the absence of detail, we would at this junction recognise that there is significant potential for adverse consequences.

More generally, the new blended models associated with the baseline payment will involve the establishment of another layer of compliance and regulation with associated time and resource implications for government and practices.

Multidisciplinary Care

Team-based care is at the heart of rural general practice and rural generalist care and as such a key domain of the ACRRM Fellowship. The College sees strong risk however, that what constitutes acceptable multidisciplinary team-based care under implemented policies could become a barrier to practices serving the most underserved of populations from access to support through the baseline payment.

Rural and remote contexts are characterised by their diversity, the smallness of their local healthcare team and chronic workforce shortages. The term *multidisciplinary* is itself problematic as it implies access to practitioners from a range disciplines, localities may only have access to staff of a single health/medical discipline. For these reasons, best practice healthcare teamwork will be governed by the realities of the local context and may vary considerably by location and constantly changing events.

It is critical that what constitutes multidisciplinary team-based care should be viewed through the lens of community needs at their most granular rather than service needs or preferences. In particular, we would recommend the terminology of *"multidisciplinary care"* be avoided and replaced with team-based care.

ACRRM Recommendation 6:
The term *"multidisciplinary"* should be avoided in favour of the term team-based care throughout the recommendations. The recommendations should provide specific instruction

that in scope care models should enable context appropriate arrangements that reflect community exigencies especially in remote and rural locations.

Comprehensive data provision

It is well documented that excessive administrative burdens are one of the key sources of dissatisfaction among General Practitioners. The 2023, RACGP annual survey found that regulatory and compliance burden and burnout are the dominant issues leading to General Practitioners considering a reduction to the amount of time they spend practising, or to cease practise.[13]

While it remains unclear how onerous the envisaged compliance and administration will be, the strengthening of the linkages between performance of further administration with access to core funding is a concern. There is potential for this requirement to present a disincentive to general practice, rather than an enabler for stronger services.

We would also note that irrespective of allocation of team workloads, data collection requires time and resource allocation away from the provision of patient care. Any expansion to requirements in this space must recognise and weigh up the opportunity cost to patient care. We would strongly recommend a judicious approach be taken in the scale and scope of any further reporting requirements.

ACRRM Recommendation 7:
The proposals should include specific direction: (a) that the imposition of data requirements is subject to a cost benefit analysis of the time and resource cost to provision of primary care in the local setting, and (b) consideration of the practical feasibility of meeting data requirements given the exigencies and resource capacities particularly of small rural and remote practices.

Patient and Practices join MyMedicare

It is noted that there has been a history of reluctance on the part of many medical professionals and patients to be enrolled in similar health data storage frameworks due to privacy and confidentiality concerns. While detail is not yet available, the proposals would deem eligibility for the baseline payment and thereby potentially practice viability contingent on both the patients and the doctors enabling their personal data to be stored in this way.

While it is noted that *MyMedicare* engagement would not technically be mandatory for practices or patients, for rural and remote communities, there is little if any patient choice in terms of the accessible medical practices and for the practice, there is limited capacity for financial viability. At a practical level therefore, this proposal would serve to either force both practices and patients to take part in *MyMedicare* despite any in principle objections or would further restrict rural and remote families' already limited access to basic healthcare.

[13] RACGP (2023) General Practice Health of the Nation 2023 https://www.racgp.org.au/general-practice-health-of-the-nation-2023

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Additionally, the risk and/or fear of lack of privacy associated with *MyMedicare* may present specific barriers to accessing basic medical care for people in a range of difficult circumstances including people seeking anonymity due to domestic violence concerns.

ACRRM Recommendation 8:
Facility should be included within the incentive's framework, to ensure primary care services can be provided to people and practices that do not sign up for *MyMedicare* especially in rural and remote areas where choices are limited, and for individuals with specific extenuating circumstances related to their privacy.

Recommendation 2

The Australian Government should invest in enabling reforms to support the new general practice payments architecture within the context of a cohesive vision for primary care by 2032.

The enabling reforms should:

- *Promote the provision of safe, accessible, high quality and value-based care across all primary care services through reforms to accreditation*
- *Enable general practices to transition to new arrangements by funding change management activities, such as education and training to practices and clinicians, investment in digital maturity in support for clinical governance*
- *Achieve accountability and support fairness for general practices, providers, and patients*

It is noted that this recommendation extends the eligibility for support under the new payment frameworks to "non-traditional" general practice models which will enable "general practice incentive payments" to flow to wholly non-medical health services.

As detailed above, while this is welcomed in so far as it may create opportunities to broaden provision of services to people in rural and remote localities without doctors, there are no structures either within the National Safety and Quality in Healthcare Standards (NSQHS) frameworks nor within the review proposals that would require, incentivise, or encourage wholly non-medical practices to seek to provide or facilitate access to General Practitioners particularly in a continuing care relationship.

The College considers it critical that every primary care provider especially in rural and remote areas should either include a General Practitioner or incorporate mechanisms to facilitate access to patients of that services having a continuing care relationship with a General Practitioner by whatever means is most effective and feasible within their context (e.g. through regular visits, telehealth, or a combination of both).

In general, ACRRM supports a team-based approach to providing patient-centred care, provided that standards of quality, safety and continuity are maintained; each team member is working to an appropriate scope of practice; and there is ongoing collaboration and communication between all members of the team. We see this approach as critical to ensuring high quality care in rural and remote contexts.

ACRRM Recommendation 9:
Eligibility of any non-medical practices for support through the GP incentives architecture should be contingent on their commitment to demonstrating business structures to enable patient access to continuous care by a General Practitioner though a context appropriate model of care.

Recommendation 3

While maintaining the principle that general practices are able to establish fees for medical services that consider their own costs and economic imperatives., the Australian Government should commission an independent primary care pricing authority to determine Commonwealth payments to general practices and primary care.

A new independent primary care pricing authority should:

- *Provide evidence-based recommendations and advice to the Minister for Health and Aged Care (the Minister) on the payment design and level of MBS rebates, including the level of blended payment mix in primary care expenditure*
- *Gather data on the costs of providing team based primary care services which will underpin pricing recommendation to the Minister*
- *Contribute to the growth in publicly available data on the primary care sector, including its scale, performance, infrastructure, training activities and research engagement*
- *Support the Government and the Department of Health and Aged Care in the ongoing design, implementation, and evaluation of general practice payments*
- *Regularly report on the financial sustainability of the primary care sector, including the cost-effectiveness of providing primary care compared to the secondary and tertiary care sectors*
- *Monitor innovations in funding arrangements, for example pooled funding across hospital and primary care settings*

ACRRM welcomes the concept of an independent authority that would give advice on payment design and the level of MBS rebates. With the transition to 40% of general practice payments occurring outside of the MBS system there would be clear value in ensuring that these in combination are and remain in sync with cost structures and community need.

Ensuring General Practitioner workforce is valued

This presents an important opportunity for building and embedding a better value case for remunerating general practice.

A significant risk is that the value of General Practitioners will not be clearly differentiated from broader primary care costs and values. As the body would be authorised to consider costs structures of both general practice and the wider primary care sector, the value, incentive structures and ideal scope of individual General Practitioners and Rural Generalists may well be subjugated or compromised within broader system priorities.

Whatever the costs and values may be for the primary care sector as a whole, the individuals that make up the healthcare workforce will respond to the incentives available to their chosen professional pathway.

In the case of General Practitioners and Rural Generalists they will need to train for a minimum of ten to twelve years to gain their professional qualifications and will realistically pursue a path that will provide reasonable return on investment on their efforts.

Ensuring the Rural Generalist workforce is valued

The authority also presents a great opportunity to appropriately measure the role and value of rural generalist practice. There is risk however that the opposite may occur, and general practice will be measured without any recognition of the role, value, and opportunities of rural generalist models of service.

While the Rural Generalist scope extends beyond what is often viewed as the primary care scope, in many rural and remote areas this scope is essential to the provision of the core medical care needs of the community. Failing to incorporate rural generalism will miss the opportunity to accurately calculate the costs and values associated with providing communities with the care they need.

Funding considerations

As noted above, this advice is given in the absence of detail of the funding allocations associated with these proposals. It is noted that the authority will create another cost and resource intensive layer of regulation, which may come at some opportunity cost for other important funding measures in the health budget.

ACRRM Recommendation 10:
The Independent Pricing Authority should include an explicit brief to identify the value and from this infer an appropriate incentivization price point to maintain a General Practitioner workforce, including a specified level for those in remote and rural areas. Similarly, it should have a specified brief to identify the value and thereby appropriate incentivization targets for General Practitioners providing rural generalist services.

Recommendation 4

The Australian Government should facilitate an effective transition to the new payment model to achieve the vision for general practice.

The transition should include:

- *A Government commitment to continuity of services and funding including research and modeling of the effects of reforms on the primary care sector including through the Medical Research Future Fund (MRFF)*
- *A phased approach to implement the reforms which delivers more funding to primary care in the early phases of the roll-out*
- *Partnership and engagement with the primary care sector during the design and implementation of these reforms, including investment in education and training for the sector to transition to the new payment model*
- *Continuous, clear communication with stakeholders and the primary care sector*
- *A continuous cycle of monitoring and evaluating reform outcomes and using these learnings to refine and test subsequent funding model evaluations*

The proposals provide only high-level detail around this recommendation.

The College notes the comments made in a number of consultation events that there is an urgency to these proposals and an appetite to progress these proposals with expediency.

As outlined above, there are concerns for example that there will be critical time gaps between rural and remote practices' structural capacity to benefit from new streams of money, and the cessation of current funding streams. Adverse impacts may come not just from actual financial outcomes but also from market expectations of future viability and value propositions, particularly for practices interested in business succession and seeking to recruit new staff.

The costs of a misstep in these proposals are high, particularly for people who live in remote and rural areas whose access to basic medical services is already poor and whose workforce across all health professions is in short supply.

We recommend that appropriate timeframes are implemented with appropriate opportunities to review progress and adjust policies in the wake of any adverse consequences.

ACRRM Recommendation 11:
Implementation plans should recognise the potential of the engendered policy changes to trigger loss of vital rural and remote medical workforce and services and ensure that all initiatives are rolled out incrementally with opportunity to expediently identify emergent negative impacts and realign.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *Healthy rural, remote and First Nations communities through excellence, social accountability and innovation.* It provides a national Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the AMC to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which commonly experience poor access to local specialist and allied health services.

ACRRM has some 5000 rural doctor members including over 1000 registrars, who live and work in rural, remote, and Aboriginal and Torres Strait Islander communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander peoples as the custodians of the lands and waters where our members and staff work and live across Australia. We pay respect to their elders, lores, customs and Dreaming. We recognise these lands and waters have always been a place of teaching, learning, and healing.